

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34807**
Registrar's No. **9015**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis 2179	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Memorial Home, 2609 S. Grand		d. STREET ADDRESS (If rural, give location) 2609 S. Grand Blvd.	

3. NAME OF DECEASED (Type or Print)	a. (First) LOUIS B	b. (Middle) AUER	c. (Last) Bauer	4. DATE OF DEATH (Month) (Day) (Year)
				Oct. 12, 1951

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 21, 1866	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (State or foreign country) Jackson, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Bauer	13b. MOTHER'S MAIDEN NAME not known	14. NAME OF HUSBAND OR WIFE Emma Bauer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME Mrs. A. Zell	ADDRESS 2609 S. Grand Blvd.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chol. Thromboembolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H22.2
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22. I hereby certify that I attended the deceased from **Apr. 10, 1946**, to **Oct 12, 1951**, that I last saw the deceased alive on **Oct 11, 1951**, and that death occurred at **10:39 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Edward F. Nelson MD (Degree or title)	23b. ADDRESS 3903 Olive St. Rainier, Mo	23c. DATE SIGNED 10-12-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE 10/15/51	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D. BY LOCAL REG. OCT 13 1951	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. CRAIG	ADDRESS 4700 WASHINGTON
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~me~~ or by Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

W. W. Wilkins

Licensed Embalmer No.

3575

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.